The Health of New Hampshire's Community Hospital System

A Financial Analysis

Elliot Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MOODY'S BOND RATING: A2
STANDARD & POOR'S BOND RATING: A-

ELLIOT HOSPITAL, MANCHESTER, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Elliot Hospital is a 238-bed, acute-care facility serving Hillsborough County[3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (57 and 27%, respectively)[4].

Until 1994, Elliot Health System was the nonprofit parent company of Elliot Hospital. In 1994, Optima Health, Inc. became the parent to the hospital, and as a member of the Optima system, Elliot Hospital was affiliated with Catholic Medical Center and St. Joseph's Hospital in additional to numerous other nonprofit and for-profit healthcare entities.

Summary of Financial Analysis 1993-98
Elliot Hospital's financial performance over the period was strong, though operating profitability declined sharply in 1998, and total margin became more dependent on nonoperating activities since 1995. The hospital was able to generate a large amount of liquidity over the period and to reduce its level of financial risk. Operating losses in 1998 caused a decline in total profitability that negatively impacted liquidity and debt coverage indicators.

Cash Flow Analysis 1993-98
Elliot Hospital generated enough cash internally to meet its investing and financing needs without additional long-term borrowing. Strong profitability, though declining in recent years, represented 46% of the total cash sources over the period. More cash was generated from nonoperating (26%) than operating activities (20%.)

Nonoperating adjustments (depreciation) generated almost one-third of the total cash. Additionally, close to $9M was reclassified as unrestricted from restricted funds following an accounting policy change, generating an additional 10% of the total cash available. Finally, working capital represented a net source of cash, due mostly to slowed payments to vendors, as reflected in the increase in average pay period, and an increase in third party reserves, which contributes to lower operating margins.

The largest use of cash was investment in property, plant, and equipment (PP&E) (51% of total uses). Though this was 55% more than depreciation expense over the period, most of this investment occurred in recent years; the average age of plant increased over the period.

The hospital spent over one-third of its cash increasing cash balances, both marketable securities (30% of total cash sources) and the cash account (5%), generating a large amount of liquidity – 311 days of unrestricted cash by 1998. This level of investment also produced the investment income that became increasingly important for boosting the bottom line as the operating margin deteriorated in recent years.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Equity transfers to Optima, offset by collections of loans to affiliates, absorbed 8% of the hospital's total cash. The total amount transferred to Optima over this period was $10M, resulting from yearly transfers beginning in 1995 that increased from $1.5M to $3.8M in 1998. Other transactions with Optima resulted in net outflows to the hospital and are reflected in the operating income. Charges to the hospital for services purchased from Optima increased from $9.8M in 1995 to $12.8M in 1998, peaking at $15M in 1997.

Ratio Analysis 1993-98[5]

Profitability

After joining Optima in 1994, profitability steadily declined, particularly operating profits. Deductibles rose faster than the markup after 1994, and markups actually dropped in 1998, contributing to the only operating loss of the period. Operating expenses increased faster than revenues throughout the period, in part due to services purchased from Optima Health.

Despite the decline in operating profitability, the hospital maintained fairly strong total margins due to the contribution of nonoperating gains, mainly from investment income. Realized gains on the sale of investments became increasingly important in recent years, contributing one quarter of the bottom line in 1996 and 1997.

Liquidity

The hospital's liquidity is strong. The current ratio shows that the hospital can easily cover its current obligations with current resources. Although this measure dropped in 1998 following a decrease in the cash account, the inclusion of unrestricted marketable securities illustrates that the hospital has more than enough liquidity to cover its short-term liabilities.

The trend in days cash on hand reflects the hospital's use of cash to invest in marketable securities and to increase the cash account. By 1997, the hospital is in the highest 10th percentile in the state in the number of days cash with short-term sources – 89 days versus a state median of 32 days. Although this measure dropped in half in 1998, the hospital was still able to double its days cash over the period. The addition of unrestricted marketable securities reveals the hospital's large amount of liquidity – 311 days of unrestricted cash by 1998.

Vendor payments remained below 40 days, a fairly quick payment cycle. Receivables are also collected quickly, in under 60 days throughout the period.

Capital Structure

The equity financing ratio (equity/total unrestricted assets) demonstrates that Elliot Hospital's capital structure is similar to other New Hampshire hospitals. Since the hospital was able to repay long-term debt without increasing its borrowings, its level of financial risk decreased over the period. Growth in equity due to high profitability ($44M) improved the hospital's solvency, despite the $10M in transfers to Optima Health. The slight decline in equity financing in 1998 was due to large operating losses and a large equity transfer to Optima of $3.8M.

Cash flow generated from net income was more than enough to service debt principal and interest payments, as illustrated by the debt service coverage ratio. In fact, the hospital could easily service its debt using just cash from operating income, though the large operating loss in 1998 resulted in a sharp decrease in this ability. Cash flow to total debt has declined steadily over

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

recent years, which may limit the hospital's future borrowing ability, especially if operating losses continue.

Charity Care and Community Benefits

Charity care reported as charges forgone represented 1-2% of gross patient service revenues from 1993 to 1998. This amount of charity care did not meet the estimated value of the hospital's tax exemption. In recent years, charity care with the addition of 50% bad debt met estimated tax benefits, though prior to 1996, in the years of increased profitability, 100% bad debt was needed to meet this benchmark.

The hospital reported additional quantifiable community benefits in the footnotes to its financial statements totaling $8.1M over the period. These activities included donations to community charities (Manchester Community Health Center and Child Health Services) and provision of various community service programs. With these amounts added to free care, charity care meets the estimated tax benefits in 1993, 1997 and 1998. Fifty percent bad debt is needed in 1996, and 100% bad debt is needed in 1994 and 1995 to meet this benchmark.

In addition to its charitable activities, Elliot Hospital offered HIV/AIDS services and operated a neonatal intensive care unit (NICU) and trauma center[1], which may be considered additional charitable benefits to the community.

Cash Flow Analysis 1993-1999

Since 1993, Elliot Hospital has generated 47% of its cash flow from its profitability (27% from non-operating income; 20% from operating income). Non-cash expenses (depreciation and amortization) generated the next largest amount at 38%. Transfers from restricted to unrestricted funds represents 10%.

Elliot has used the majority of its cash increasing its property, plant, and equipment (PP&E) (58%; somewhat higher than the aggregate 51% in 1993-1998), followed by 22% investments in board- designated funds. 12% was transferred to Optima and other affiliates. 1% was used to increase its cash account, a slight change from last years 6% aggregate amount.

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1999 Ratio Analysis

Profitability

This year, the hospital's profitability continues to erode, as it has been doing since 1996. Its total margin has decreased from 4% in 1998 to 1% in 1999, due primarily to a significant drop in investment income relative to prior years. Profit from operations has improved from –4% to breakeven largely due to an increase in net patient service revenue.

Liquidity

In spite of the decline in total profitability, the hospital remains liquid. Even without including board-designated funds, the hospital is able to meet its short-term liabilities. If we include board-designated funds, the hospital is able to pay its short-term liabilities 4.93 times over. The hospital maintains an average of 49.64 days in accounts receivable, and its average payment period is 34.67 days (among the most favorable in the state). The hospital's current days cash on hand has steadily decreased since 1995 (30.92 days in 1999). However, if board-designated funds are included, the hospital has nearly 267 days cash on hand (which is average for New Hampshire but well above the national average).

Capital Structure

The hospital retains an equity financing ratio of 0.65 in 1999 (average for New Hampshire but favorable when compared to the national average). The hospital continues to generate enough cash to service its debt from operating income alone (debt service coverage: 2.67); when considering all sources of income, debt service coverage is 3.07 times in 1999. Elliot has a relatively low risk financial structure.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 1.32% of gross patient service revenue (GPSR) - up from 1.24% in 1998. The hospital wrote off 4.91% of the GPSR as bad debt; again, this was an increase from 4.50% in 1998. The hospital also contributed to several community service programs including patient transport services, prenatal education programs, health screening, and other health education and information services. These additional benefits amounted to $871K in 1999.

Summary

Overall, Elliot Hospital is in fairly good financial standing. In spite of declining profits, the hospital has substantial cash reserves, and its capital structure remains relatively low-risk.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health